HealthCare Review Corporation
IMPACT Plus Case Manager and Sub-Provider Trouble Shooting Form
(Please remember to submit materials needed to solve the problem) **Today's Date** _____

SECTION A

Name (Person Completing Form) _____ **Phone (W)** _____ **(F)** _____

Agency _____ **Address** _____ **City** _____ **State** ___ **Zip** _____

Name of Case Manager: _____ **Agency** _____ **Phone: (W)** _____ **(F)** _____

SECTION B

Please place a mark next to the most appropriate choice.

____ Billing Problem (If P.A. problem, please send a copy with this form) ____ Need Status of RFS ____ Amendment ____ Other _____

SECTION C

Client Name	Medicaid #	Impact Plus Procedure Code	Begin Date	End Date	Units Req.	Units Auth.	Provider (Please use their billing name)	Problem
Example John Smith	999999999	X0064	12/1/99	3/1/00	3	3	Counseling Unlimited	Received letter authorizing 3 units but PA listed only 2 units
								A.
								B.
								C.

Further Explanation of Problem

_____ _____
Case Manager / Sub-Provider Signature Date Completed

HRC Only

_____ _____
HRC Signature Date Completed